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Clash of the Titans: Medicaid Meets Private Health Insurance

Sara Rosenbaum*

INTRODUCTION

Throughout its first forty-eight years of life, the federal Medicaid statute lacked a viable insurance pathway for most low-income adults[1] ineligible for employer-sponsored coverage. In what is arguably the most important public health achievement since the enactment of Medicare and Medicaid fifty years ago, the Patient Protection and Affordable Care Act (ACA)[2] fundamentally alters this picture. Building on earlier breakthroughs for children, the ACA restructures Medicaid to cover poor adults and juxtaposes its new architecture against an affordable and accessible private insurance market for people ineligible for employer-sponsored or government insurance.

These reforms have already produced measurable results. But they also hold important implications for the future of Medicaid. Since its creation, Medicaid has permitted states to use federal funding to purchase private health insurance. Until the ACA, however, there was essentially nothing to buy. Now, by pairing the largest of all need-based programs—one infused with the concept of social contract—with an affordable private insurance market, the ACA undoubtedly has set the stage for profound changes over time in how Medicaid functions. This transformation in how Medicaid is designed and administered was, in fact, discussed during the legislative run-up to the ACA's enactment, but nothing came of it. Now, through a terrible twist of fate, this transformation is happening anyway, in the form of large-scale federal demonstrations—negotiated in the main out of public view[3]—in an intense bid to undo the damage to the Medicaid

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1. In this essay the term includes people who live in families with household incomes up to twice the federal poverty level.

2. The ACA actually consists of two laws: The Patient Protection and Affordable Care Act , Pub. L. No. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029, enacted immediately following the ACA's passage.

3. Federal regulations require that demonstration proposals submitted by states and authorized by section 1115 of the Social Security Act, 42 U.S.C. §1315 (2012), be publicly posted for notice and comment. 42 C.F.R. §431.416(b) (2012). States also must permit comments once the demonstration begins. 42 C.F.R. §431.420(c) (2012). But like other CMS Medicaid policy-making regulatory processes, the actual negotiation process is closely held.

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expansion caused by the United States Supreme Court's decision in *National Federation of Independent Business v. Sebelius.*[4]

The demonstrations approved to date have largely succeeded in generating state buy-in to the adult expansion without unraveling core Medicaid safeguards for the poor. But whether the Obama Administration, now in its twilight and eager to get states on board,[5] can or will continue to hold the line is anyone's guess. And with a private insurance market there to impose direct pressure on Medicaid, will a new Congress—politically light years away from the one that enacted the ACA—sweep away Medicaid's remaining vestiges for that part of the Medicaid population whose eligibility is based on income alone? If so, what will be lost?

Following a background, on public and private health insurance for the poor prior to enactment of the ACA, I discuss the competing visions for low-income Americans created under the Act and the extent to which the U.S. Department of Health and Human Services (HHS) Secretary's use of her Medicaid demonstration powers may be moving Medicaid increasingly in the direction of a subsidy program for private insurance products. I also describe the ways in which the HHS Secretary has held the line on Medicaid's foundational elements and what this political deal-making means for the 114th Congress that convenes in January 2015, which promises to be one in which many of Medicaid's basic tenets will be re-examined, and potentially, fundamentally altered.

I. BACKGROUND

A. Private Health Insurance for the Poor, Pre-ACA

Although legally it always could do so, Medicaid did not face real pressure to buy private insurance in the pre-ACA time period because, for its beneficiaries, there was basically nothing to buy.[6] The "accident of history"[7] that became the voluntary system of employer coverage we know today has always been inherently irrational for low-wage workers. Employer insurance reached a zenith of sorts around the mid-1970s, covering around 70 percent of the U.S. working-age population, and has been declining since.[8] In 1984, following a deep recession that

4. 132 S. Ct. 2566 (2012).

5. Just how eager the Administration may be to use its section 1115 authority to move further on the Medicaid expansion can be seen in HHS Secretary Sylvia Burwell's Medicaid expansion outreach to Republican Governors immediately following the 2014 mid-term elections. Susan Ferrechio, *HHS Secretary to Tuesday's Gubernatorial Winners: Call Me*, WASH. EXAMINER, Nov. 4, 2014, http://www.washingtonexaminer.com/hhs-secretary-to-tuesdays-gubernatorial-winners-call-me/article/2555681.

6. Sara Rosenbaum & Benjamin D. Sommers, *Using Medicaid to Buy Private Health Insurance–The Great New Experiment?*, 369 NEW ENG. J. MED. 7, 8 (2013).

7. David Blumenthal, *Employer-Sponsored Health Insurance in the United States–Origins and Implications*, 355 NEW ENG. J. MED. 82, 82 (2006).

8. Jon Gabel, *Job-Based Health Insurance, 1977-1998: The Accidental System Under Scrutiny*,

significantly increased the number of uninsured people, less than a quarter of nonelderly low-wage earners reported workplace coverage.[9] By 2012, after several more recession and recovery cycles, the proportion of poor nonelderly Americans with workplace coverage had fallen by half, to slightly more than 13 percent.[10] The decline was equally precipitous among the near-poor; among workers with family incomes between one and two times the federal poverty level, employer coverage rates fell from nearly 62 percent to less than one-third.[11] These figures were consistently worse for children, a fact that helped propel the Medicaid expansions of the 1980s.[12] In 2012, less than 9 percent of poor children had employer coverage; among near-poor families, children's coverage stood at less than 30 percent.[13]

Without employer insurance there was no private insurance alternative to speak of. Health insurance trend data covering the same 1984-2012 time period show that even when all sources of private insurance were taken into account, the proportion of low-income Americans with private coverage rose only marginally.[14] In order to guard against adverse selection,[15] individual private insurance was unavailable to most and unaffordable even when people could qualify for it.

Medicaid did relatively little to relieve this misery. Grounded in cash welfare traditions,[16] Medicaid essentially left out working-age adults unless they were either totally disabled or caretakers of minor children. Pregnancy would later be added as an eligibility category in its own right along with reforms for children, and welfare reform enabled states to broaden coverage of parents. But in the main, Medicaid excluded poor adults, even within those eligibility categories for which

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18 HEALTH AFF. 62, 65 (1999). The trends found by Gabel persisted into the 21st century. *See, e.g.*, *Health, United States, 2013*, U.S. DEP'T HEALTH & HUM. SERVS. 353 tbl.123 (2013), http://www.cdc.gov/nchs/data/hus/hus13.pdf.

9. *Id.*

10. *Id.*

11. *Id.*

12. Sara Rosenbaum & Genevieve Kenney, *The Search for a National Child Health Coverage Policy*, 33 HEALTH AFF. 2125 (Dec. 2014).

13. *Health, United States, 2013 supra* note 8, at 354 tbl.123.

14. In 2012, for example, considering all sources of private health insurance, the proportion of poor privately insured people stood at 16.5 percent (compared to 13.6 percent) while the proportion of near-poor people with private coverage rose from 32.2 percent to 36.7 percent. *Health, United States, 2013*, *supra* note 8, at 350 tbl.122.

15. TIMOTHY S. JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER DRIVEN MOVEMENT (2007).

16. ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID (1974). The welfare philosophy underlying Medicaid was vividly on display in Chief Justice Roberts' Medicaid opinion, which focused on the degree to which the ACA Medicaid expansion departed from a philosophy of helping "the neediest among us," thereby imposing an entirely "new program" on the states in an unconstitutionally coercive fashion. Nat'l Fed. of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2604-09 (2012).

federal funding was available, such as parents.[17] A handful of states extended Medicaid to poor adults through federal demonstrations undertaken pursuant to section 1115 of the Social Security Act.[18] But low-income, nonelderly adults were relatively invisible in Medicaid unless they were fully disabled; as of 2012, Medicaid reached only 52 percent of poor adults, and 30 percent of those who were near-poor,[19] and about 3 in 10 poor and near-poor adults remained completely uninsured.[20] Furthermore, because of a phenomenon known as "churning"—the rapid movement on and off various forms of insurance coverage—adults who did obtain Medicaid rapidly lost it, victims of even slight shifts in life circumstances such as income fluctuation, marriage, divorce, or a child reaching adulthood.[21]

B. The Affordable Care Act

The ACA has utterly changed this picture for low-income adults, at least those who are U.S. citizens or legal U.S. residents.[22] By creating an affordable insurance market, extending Medicaid to all nonelderly low-income adults with family incomes up to 138 percent[23] of the federal poverty level,[24] and establishing a system of tax credits for persons with incomes between 100 percent and 400 percent of poverty and ineligible for minimum essential coverage through employer plans or government insurance,[25] the ACA uses Medicaid to create coverage for the poor while building subsidized insurance next door.

Family income delineates the two markets down to the dollar: family income up to 138 percent of the federal poverty level qualifies a 63-year-old woman for Medicaid, while family income starting at 139 percent of poverty results in

17. Sara Rosenbaum, *Medicaid and National Health Reform*, 361 NEW ENG. J. MED. 2009, 2010 (2009).

18. *See* John Holahan et al., *Insuring the Poor Through Section 1115 Medicaid Waivers*, 14 HEALTH AFF. 199 (1995).

19. *See Health, United States, 2013*, *supra* note 8 at 356 tbl.124.

20. *Id.* at 359 tbl.125.

21. Benjamin D. Sommers et al., *Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options Can Ease Impact*, 33 HEALTH AFF. 700, 700-01 (2014).

22. Thirteen percent of the uninsured remain ineligible for assistance under the ACA because of immigration status. *See How Will the Uninsured Fare Under the Affordable Care Act?*, KAISER FAM. FOUND. (2014), http://kaiserfamilyfoundation.files.wordpress.com/2014/04/8531-how-will-the-uninsured-fare-under-the-aca.pdf.

23. Technically, the Medicaid statute specifies 133 percent of poverty as the Medicaid eligibility stopping point. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012). However, the ACA's legislative companion, the Health Care and Education Reconciliation Act (HCERA), reset the upper income threshold at 138 percent of poverty. Health Care and Education Reconciliation Act (HCERA) of 2010 § 1004(e), 42 U.S.C. § 1396e(14) (2012).

24. Patient Protection and Affordable Care Act (ACA) § 2001, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012).

25. Patient Protection and Affordable Care Act § 1401, (codified at 26 U.S.C. § 36B(c)(2)(B) (2012)).

subsidized private insurance. People entitled to Medicaid receive the full benefits of Medicaid enrollment: the right to apply at any time; retroactive eligibility to help with incurred medical bills; comprehensive coverage without cost-sharing; and other benefits that are unusually broad. They also experience Medicaid's shortcomings, in particular, greater problems with access to care,[26] although early reports suggest that physicians in some regions of the country may be balking at patients insured through Exchanges as well.[27]

Low-income individuals who qualify for premium subsidies receive subsidies toward the cost of coverage, as well as cost sharing assistance. Neither premium subsidies nor cost sharing reduction assistance are what they should be for lower income people. Using my home town of Alexandria, Virginia as an example, a 45-year-old mother of two earning $39,600 in 2014 (203 percent of the federal poverty level)[28] will still have to pay over $200 per month (more than 6 percent of her monthly household income) for family coverage in 2015. Because her income slightly exceeds twice the federal poverty level, her children will not qualify for the Children's Health Insurance Program in Virginia, which the state cuts off at 200 percent of the federal poverty level. Furthermore, she will qualify for a family health plan with only a 73 percent actuarial value, since the ACA's more generous cost-sharing subsidy assistance ends at twice the federal poverty level.[29] This will leave her facing steep cost-sharing for covered services as well as sizable premiums. Even if we assume self-only coverage (because her children qualify for public insurance) and a much lower household income—$27,000 (143 percent of

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26. *See, e.g.*, Robert Pear, *For Many New Medicaid Enrollees, Care is Hard to Find, Report Says*, N.Y. TIMES, Sept. 27, 2014, http://www.nytimes.com/2014/09/28/us/for-many-new-medicaid-enrollees-care-is-hard-to-find-report-says.html (reporting on a new report from the HHS Office of the Inspector General examining managed care and health care access); *see also State Standards for Access to Care in Medicaid Managed Care*, U.S. DEP'T HEALTH & HUM. SERVS. (2014), http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf.

27. *ACA Exchange Implementation Survey Report*, MED. GRP. MGMT. ASS'N. (May 2014), http://www.mgma.com/government-affairs/issues-overview/aca/aca-exchange-implementation-report/aca-surveyreport_online_2?ext=.pdf.

28. In this hypothetical the family has household income equal to 203% of the federal poverty level for a family of 3 in 2014. *Health Reform Subsidy Calculator*, KAISER FAM. FOUND., http://kff.org/interactive/subsidy-calculator/#state=va&zip=22314&income-type=dollars&income=39%2C590&employer-coverage=0&people=3&alternate-plan-family=individual&adult-count=1&adults%5B0%5D%5Bage%5D=45&adults%5B0%5D%5Btobacco%5D=0&child-count=2&child-tobacco=0 (last visited Dec. 7, 2014). The Children's Health Insurance Program (CHIP), known in Virginia as Family Access to Medical Insurance Security (FAMIS), subsidizes insurance coverage for Medicaid-ineligible low-income children with household incomes up to twice the federal poverty level. In Virginia, children in a family of 3 do not qualify if their household incomes exceed 200 percent of the federal poverty level ($39,580 in 2014). For a family of 3, CHIP eligibility ceases at $39,580.

29. Patient Protection and Affordable Care Act § 1402(c)(1)(B)(i), (codified at 42 U.S.C. § 18071 (2012)).

poverty)—the woman in my example still would have to pay nearly $100 per month for her own coverage. Were her income to drop below 139 percent of poverty in Virginia, she would qualify for nothing, since Virginia is a non-adult-expansion state.

With the near-derailment of the adult Medicaid eligibility expansion by *Sebelius*, the Medicaid expansion, initially projected to reach some 16 million people when fully implemented,[30] has not worked as intended. As of November 2014, 23 states continued to refuse to extend coverage to poor adults,[31] who are eligible for nothing at all if their incomes fail to reach the 100-percent-of-poverty threshold that defines the subsidy entitlement; states' refusal to expand left an estimated 4 million persons (85 percent of whom reside in the South) in what has become known as the "coverage gap."[32] Despite this setback, the ACA has had an enormous impact on insurance coverage for those of low income, especially in the Medicaid expansion states, where the proportion of poor residents who were uninsured fell by 4.7 percent.[33]

II. COMPETING VISIONS OF HEALTH INSURANCE COVERAGE FOR LOW INCOME PEOPLE

The creation of complementary pathways to insurance for low and moderate income people—Medicaid for the poorest, juxtaposed at the 138-percent-of-poverty point with tax-subsidized private insurance for those with low and moderate incomes—thus can be judged a landmark success. But real implications for Medicaid also lie in this juxtaposition, especially for people who need coverage far more extensive than what they will be able to purchase in the subsidized private market, and for whom the subsidy system is insufficient to meet the cost of necessary health care. Furthermore, below the surface of these two aligned pathways to coverage can be found millions of low-income people who experience income fluctuation to constantly move between Medicaid and the subsidized private insurance market.

Although more detailed studies emerged after passage of the ACA, income

30. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Harry Reid, Majority Leader, U.S. Senate (Mar. 24, 2010), http://www.cbo.gov/sites/default/files/reid_letter_hr3590.pdf.

31. Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid–An Update*, KAISER FAM. FOUND. (Nov. 12, 2014), http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/. Twenty-seven states and the District of Columbia have expanded coverage. As of that date, five of the Medicaid expansion states were proceeding with the expansion as part of a section1115 demonstration authority. Anita Cardwell & Kaitlin Sheedy, *Where States Stand on the Medicaid Expansion*, STATE REFORUM, https://www.statereforum.org/Medicaid-Expansion-Decisions-Map (last visited Nov. 7, 2014).

32. Garfield et al., *supra* note 31.

33. Benjamin D. Sommers et al., *Health Reform and Changes in Health Insurance Coverage in 2014*, 371 NEW ENG. J. MED. 867, 871 fig.1, (2014).

fluctuation, along with its consequences for health insurance coverage for lower income populations, was already a well-known problem when the ACA was being designed.[34] A widely cited post-ACA study places the national churn problem over the course of a year at 50 percent of low-wage workers.[35] Yet another study documents the problem of post-ACA churn in all states, even those that do not expand Medicaid to include low-income adults.[36] Indeed, in Massachusetts, home of the ACA prototype, even after years of implementation experience, churn continues to create breaks in coverage for a significant portion of the affected population. Health reform has mitigated this problem by shortening the coverage breaks considerably.[37]

The great advance of the ACA is that, as with Massachusetts, the law has the potential to dramatically reduce periods without coverage. But the bifurcation of the affordable insurance system means that breaks are essentially baked into the design of the program unless effective mitigation strategies can be developed. And coverage breaks are a major cause for concern—not only because of their implications for the continuity and quality of coverage and care but also because of their impact on risk estimates. As people cycle on and off coverage, the risk also increases that they will delay necessary health care until insurance is subsequently regained, a danger to their health and an added element of financial risk for the private insurance market.

The problem of post-ACA churn—created by the use of dual, subsidized coverage arrangements juxtaposed against one another but significantly different in design and operation—was considered during the legislative process. But in the intense atmosphere surrounding enactment, efforts to more meaningfully address the problem were set aside. The principal mitigation strategy adopted was the ACA's redesign of the process by which individuals enroll in coverage and retain it.[38] As we know, however, for a constellation of reasons—technical, operational, political, structural—the American health insurance system is light years away from the ideal of streamlined enrollment. Furthermore, streamlined enrollment

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34. *See, e.g.*, Gerry Fairbrother et al., *How Stable is Medicaid Coverage for Children?*, 26 HEALTH AFF. 520 (2007); Pamela Farley Short & Deborah R. Graefe, *Battery-Powered Health Insurance? Stability in Coverage of the Uninsured*, 22 HEALTH AFF. 244 (2003); Pamela Farley Short et al., *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem*, COMMONWEALTH FUND (2003), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2003/nov/churn--churn--churn--how-instability-of-health-insurance-shapes-americas-uninsured-problem/short_churn_688-pdf.pdf.

35. Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges*, 30 HEALTH AFF. 228 (2011).

36. Benjamin D. Sommers et al., *supra* note 21.

37. John A. Graves & Katherine Swartz, *Health Care Reform and the Dynamics of Insurance Coverage–Lessons From Massachusetts*, 367 NEW ENG. J. MED. 1181 (2012).

38. Patient Protection and Affordable Care Act § 1413, 42 U.S.C. § 18083 (2012).

does nothing to address the fact that two distinct subsidy systems—Medicaid along with subsidized private insurance—might mean two entirely different supplier markets.

The challenges posed by the creation of two distinct markets for coverage and their implications—including the inadequacy of assistance for near-poor families—might also have been lessened through use of the Basic Health Program.[39] Modeled after a pre-ACA program sponsored by Washington State, the Program offers states the option of receiving per capita premium subsidy payments (in lieu of having these subsidies flow directly to eligible individuals and families through the Exchange), and to use the subsidies to effectively expand Medicaid coverage to reach all people with incomes up to twice the federal poverty level. The evidence suggested that such an approach would significantly smooth the subsidy transition problem by pushing the point of churn higher, to a level at which far more people qualify for employer coverage.[40] It was also clear that the Program would enable states to far more significantly assist lower income families. But the Obama Administration delayed in implementing the Program;[41] as of fall 2014, no state has moved ahead.

Since passage of the ACA, another strategy to reduce churn has emerged: that of using multi-market health plans. In many markets, a distinct managed care industry serves Medicaid, while companies specializing in subsidized private insurance plans operate in the Exchange. The problem of distinct supplier markets and their implications for a churning population received virtually no attention during the legislative process. However, subsequent research suggests that companies may now be developing multi-market strategies under which the same, or linked, products are marketed and sold to families and individuals as a means of reducing the care disruptions caused by churn. But the problem facing these companies is building networks of providers willing to accept all plan members regardless of source of subsidization, since the source of the subsidy (Medicaid versus private insurance) almost always determines provider payment levels.[42]

Discussions during the legislative development process about how to mitigate churn through state options building on the program's historic flexibility to

39. Patient Protection and Affordable Care Act § 1331, 42 U.S.C. § 18051 (2012).

40. Ann Hwang et al., *Creation of State Basic Health Programs Would Lead to 4 Percent Fewer People Churning Between Medicaid and Exchanges*, 31 HEALTH AFF. 1314 (2012).

41. Final regulations implementing the Basic Health Program (BHP), a complex program that requires complicated funds transfers between federal and state governments, were not issued until 2014. *See* Basic Health Program: Federal Funding Methodology for Program Year 2014, 79 Fed. Reg. 13,887 (Mar. 12, 2014). It was not clear whether the Administration simply was unable to develop implementation standards in time or sought to discourage the removal of lower income workers from the Exchange pool out of concern about the impact of doing so on the viability of Exchanges.

42. Sara Rosenbaum, *Addressing Medicaid/Marketplace Churn Through Multi-Market Plans: Assessing the Current State of Play* 40 J. HEALTH POL., POL'Y & L. 233 (2015).

purchase private health insurance[43] might have gotten some traction had it not been for the problem of cost. Allowing Medicaid under certain controlled circumstances to purchase coverage from private health plans inevitably entails a significant increase in costs because of the marked differential between Medicaid provider payment and rates paid by private insurance.[44] Just how big an investment would be needed to position Medicaid to purchase Exchange coverage was not known, since the Congressional Budget Office (CBO) never released formal cost estimates. But the magnitude of the additional spending that would be needed became clear following *Sebelius,* when CBO re-calculated the financial impact on the federal government of states' refusal to expand Medicaid. The CBO concluded that the absence of a Medicaid expansion would result in the movement into the Exchange of millions of people with incomes between 100 percent and 138 percent of the federal poverty level, and that per capita spending for this population would be 50 percent higher on average.[45] This estimate exposed the fact that the Medicaid expansion was a principal means by which federal outlays for low-income people had been contained.

III. THE SECTION 1115 PROCESS POST-*SEBELIUS*

Here matters would have sat but for section 1115 of the Social Security Act, which enables the HHS Secretary to waive certain, otherwise-applicable provisions of law governing Medicaid and other state grant-in-aid programs in order to carry out an "experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of" the program in question.[46] With a long and storied history, section 1115 was put to work in order to overcome the terrible blow of *Sebelius* while also permitting states to do the very thing originally discussed during the legislative process but set aside. Essentially, this redesigned the point of contact between Medicaid for the poor and a private insurance market poised to surge into being.

Predating Medicaid's enactment, section 1115 has long been a source of energy for propelling dynamic program change. The most obvious example of this tendency is that the Medicaid amendments of 1997,[47] which vastly reshaped the Medicaid managed care legislative framework, rested heavily on a series of section

43. Rosenbaum & Sommers, *supra* note 6.

44. *See* Peter Cunningham & Ann S. O'Malley, *Do Reimbursement Delays Discourage Medicaid Participation By Physicians?*, 28 HEALTH AFF. w17 (2009). Physician acceptance of Medicaid patients historically has been depressed, with payment levels presumed to play a major, but by no means the only, role in low participation. *See* MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, REPORT TO THE CONGRESS ON MEDICAID AND CHIP 123 (Mar. 2011).

45. CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 4 (2012).

46. 42 U.S.C. § 1315(a) (2012).

47. Balanced Budget Act of 1997, Pub. L. No. 105–33, § 4757(a), 111 Stat. 251, 527.

1115 Medicaid managed care demonstrations (some but not all of which combined managed care structures with eligibility expansions for low-income adults)[48] conducted during the early years of the Clinton Administration. Despite many problems,[49] these large-scale mandatory-enrollment managed care demonstrations showed that states could organize and run managed care systems, at least for beneficiaries whose eligibility was based on low family income. The demonstrations also paved the way for a gigantic Medicaid managed care industry[50] that would emerge in response to invitations to sell private-health-plan-like products to government sponsors of health care for the poor.

Arkansas has become the poster child for the modern section 1115 pathway to expanded Medicaid coverage.[51] In contrast to previous expansions, the Arkansas model uses purchased private insurance rather than Medicaid managed care as the means of achieving coverage. In this sense, Arkansas represents the ideal test case, since the state lacked a large-scale Medicaid managed care market to begin with and necessarily rested on an individual private insurance market. The model, influenced by the post-ACA churning studies showing that most newly eligible beneficiaries were working-age adults in relatively good health,[52] was designed to take advantage of the new insurance market while extending Medicaid to the poor. In this way, the demonstration combined the tradition of Medicaid as the means of insuring the poor with a resurgent private market.

It will be years before lawmakers can fully know the impact of the Arkansas experiment on access, costs, and quality. But the Arkansas model contains extremely important features[53] that should guide future policymaking. First, the model establishes Medicaid for all non-elderly low-income people who would have qualified for Medicaid under the basic terms of the ACA. The state was not permitted to proceed with this structure without agreeing to cover all non-elderly low-income adults who would have qualified for Medicaid had the state expanded the program under the ACA's original terms. In other words, the demonstration achieved a dramatic reduction in the proportion of Arkansans without health insurance precisely because it achieved coverage of the federally targeted population under the ACA itself.

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48. *See* Rosenbaum, *supra* note 17, at 2011.

49. *See* John Holahan et al., *Medicaid Managed Care in Thirteen States*, 17 HEALTH AFF. 43 (1998).

50. By 2012 the industry was responsible for covering 60 million people. *Medicaid Managed Care: Key Data, Trends and Issues*, KAISER FAM. FOUND. (2012), http://kaiserfamilyfoundation.files.wordpress.com/2012/02/8046-02.pdf.

51. Rosenbaum & Sommers, *supra* note 6, at 7-8.

52. *See* Short et al., *supra* note 34, at 4 (providing a profile of people most likely to churn. Essentially, the high churning group consists of younger, whiter, healthier, married people without children and with fairly high levels of education–in other words, just whom insurers want).

53. Letter from Marilyn Tavenner, Admin., Ctrs. for Medicare and Medicaid Servs., to Andy Allison, Dir., Ark. Dep't Hum. Servs. (Sept. 27, 2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf.

Second, the Arkansas model effectively breathes life into the state's Exchange by default-enrolling those who do not select coverage on their own into private health plans.[54] In this way the demonstration links hundreds of thousands of healthy low-income Arkansans to coverage, using a compulsory system that connects those entitled to assistance to a health plan and its network. The use of private health plans to secure coverage for people entitled to Medicaid—as opposed to a distinct Medicaid managed care industry that operates much like private insurance—means that continuity of coverage and care are available regardless of changes in family income that move an individual or family from Medicaid to tax subsidies and back again. Because of the problem of deep medical under-service across the state, its safety net providers are able to participate in health plans. These plans are bound by the essential community provider network requirement applicable to plans sold in the Exchange.[55] Furthermore, for the time being at least, the demonstration does not waive the special Medicaid payment methodology for community health centers. This methodology, along with Medicaid eligibility expansions, has propelled health centers to the nation's largest system of primary health care for medically underserved communities and populations.

Third, and intimately bound up with the second achievement, the demonstration exempts from this compulsory private plan arrangement those residents (estimated at around 20 percent of the population)[56] who are deemed to be "medically fragile" because of one or more conditions that limit health activity. In other words, the design succeeds precisely because it introduces a pre-existing condition exclusion of sorts. But in this case, the exclusionary tool is used simply to determine the *type* of coverage an individual will receive, not whether coverage will be available at all. To be sure, this screening mechanism makes the entire enterprise attractive to the private insurance industry, which in turn avoids the highest risk populations. However, such screening also insulates that part of the newly eligible Medicaid population with the greatest health vulnerabilities from the harsher terms of private coverage. It may be that such screening is less than perfect in predicting higher health needs, but at least there is a tool whose impact and accuracy can be evaluated.

Fourth, the demonstration preserves Medicaid's open-access feature, arguably its single most important attribute. The fundamental principle of Medicaid enrollment at any time, regardless of health need, remains intact. This safety net feature is of incalculable value, even taking into account the special enrollment

54. Andrew Allison, *Arkansas's Alternative to Medicaid Expansion Raises Important Questions About How HHA Will Implement New ACA Waiver Authority in 2017*, 39 J. HEALTH POL. POL'Y & L. 1089 (2014).

55. 42 U.S.C. § 18031(c)(1)(C) (2012).

56. Testimony of Andrew Allison before the Medicaid and CHIP Payment and Access Commission (MACPAC), (Sept.18, 2014), http://www.macpac.gov/home/meetings/sept).

periods established under the ACA.[57]

Fifth, the terms of the demonstration guarantee the continuation of certain benefits unique to Medicaid (early and periodic screening, diagnosis and treatment for children and adolescents, highly accessible family planning services, non-emergency medical transportation), which have no equal in the commercial insurance market. Finally, the terms and conditions of the demonstration ensure that—again, at least at the moment—patient cost-sharing responsibilities remain within established Medicaid boundaries. These boundaries hold Medicaid cost-sharing well below the level that insurers are imposing on the premium subsidy population, even that portion of the population that receives the most significant level of subsidization.

Two basic problems loom, however: cost and politics. It seems inevitable that the Arkansas demonstration, by binding Medicaid premium payments to the competitive rate for silver plans established within the state Exchange, will result in costs that exceed what Medicaid would have spent for the same population under traditional coverage arrangements. In order to adhere to the budget neutrality rules that, by Executive action, have applied to section 1115 demonstrations since the late 1970s,[58] the Administration essentially permitted the state to project significant cost increases under traditional Medicaid. These cost increase projections were based on the assumption that a surge in Medicaid enrollment inevitably would have created pressure for provider fee increases in order to ensure patient access to care. Not surprisingly, this decision by the Administration has come under intense scrutiny by the General Accounting Office,[59] since it has effectively "back-doored" the same spending increases that CBO flagged in its post-*Sebelius* cost estimates.

The second cause for concern is the politics of premium assistance. Arkansas potentially represents the high-water mark for the demonstration model. The Arkansas demonstration features open enrollment, preservation of full Medicaid benefits for the medically frail, no premiums, and cost-sharing held to Medicaid's relatively modest levels. The model also maintains coverage of certain supplemental benefits for beneficiaries receiving premium support, including free choice of family planning benefits, comprehensive supplemental coverage for children and adolescents up to age 21 (typically those with serious and chronic health conditions), and non-emergency medical transportation. Furthermore, the

57. *Having a Major Life Change? You May Qualify for a Special Enrollment Period*, HEALTHCARE.GOV BLOG (Sept. 5, 2014), https://www.healthcare.gov/blog/special-enrollment-period/.

58. *Section 1115 Demonstrations*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html (last visited Nov. 2, 2014).

59. Katherine Iritani, *HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns*, U.S. GOV'T ACCOUNTABILITY OFF. (Aug. 8, 2014), http://www.gao.gov/assets/670/665265.pdf.

demonstration preserves the special Medicaid payment mechanism for community health centers, a core element of the U.S. health care safety net and a major source of care for insured and uninsured patients alike. Preservation of these elements—in particular, Medicaid's safety net financing feature—is key. Indeed, if Massachusetts' near-decade-long experience with health reform offers any lesson, health reform will produce enormous achievements while still leaving considerable gaps. States will still have a population of considerable size that remains completely uninsured for longer or shorter periods of time owing to both ineligibility for coverage (in the case of persons not lawfully present in the U.S.) and breaks in coverage as a result of churn. There will also be a considerable low-income population that, even if insured, continues to need health care (such as vision and dental care) that remains uncovered by public and private health insurance. This care will therefore be inaccessible to low-income populations in the absence of community health centers or other publicly funded providers that can make primary health care available on a heavily discounted basis.[60]

As other demonstrations have proceeded, the Arkansas model has lost a bit of ground. Later demonstration proposals approved by HHS for Iowa, Pennsylvania, and Michigan have included approvals to impose premiums on certain portions of the demonstration population and eliminate benefits such as dental care for 19 to 21-year-olds.[61] States routinely have sought to impose higher cost sharing than permitted under Medicaid. Indeed, the second phase of the Arkansas demonstration includes precisely this proposal, through the establishment of health savings accounts coupled with higher cost sharing requirements that apply to the poor.[62]

Although many states initially sought to limit the expansion to adults under 100 percent of the federal poverty level (the Exchange threshold), no state has yet come forward seeking to limit the expansion to only certain newly eligible adults falling within actuarial norms (i.e., excluding the medically frail). Nor has any state sought to eliminate Medicaid's basic open access feature, although rumors persist that such a proposal could be in the offing. Under section 1115, at least as interpreted by the current Administration, these types of proposals almost certainly would be rejected as not consistent with program goals. But the discretion to decide

60. Julia Paradise et al., *Providing Outreach and Enrollment Assistance: Lessons Learned from Community Health Centers in Massachusetts*, KAISER FAM. FOUND. (2013), http://kff.org/health-reform/issue-brief/providing-outreach-and-enrollment-assistance-lessons-learned-from-community-health-centers-in-massachusetts/; Leighton Ku et al., *How is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform*, KAISER FAM. FOUND. (2009), http://www.kff.org/health-reform/report/how-is-the-primary-care-safety-net/.

61. Sara Rosenbaum & Carla Hurt, *How States Are Expanding Medicaid to Low-Income Adults Through Section 1115 Waiver Demonstrations*, COMMONWEALTH FUND (2014), http://www.commonwealthfund.org/publications/issue-briefs/2014/dec/how-states-are-expanding-medicaid.

62. *See* Allison, *supra* note 54.

when a Medicaid demonstration advances Medicaid's objectives lies with the Secretary as a matter of law.

The close scrutiny brought to bear on the cost of Arkansas' Medicaid demonstration may signal the end of section 1115 premium assistance demonstrations as generous as the Arkansas model. Yet as the Obama Administration comes to a close, the temptation to get as many of the remaining non-expansion states into the fold will be great. A "big tent" demonstration strategy might provide some insurance against repeal efforts in a Republican controlled Congress, but broadening section 1115 significantly beyond where the Arkansas demonstration has taken the program is a risky business. Indeed, greater leeway to reduce financial support and benefits could produce the opposite effect, emboldening states and conservative lawmakers to demand broader state flexibility to accomplish without demonstration authority what today can be done only under the Secretary's special terms and conditions. In other words, this would be a replay of the Balanced Budget Act of 1997, but arguably with far greater stakes. It could culminate in Medicaid adult expansion legislation that broadly enables Medicaid's full conversion to premium assistance. Under such a scenario, the ACA coverage and financial assistance standards might become the floor, assuming that these standards survive.

There are, in fact, limits to how extreme a Medicaid makeover might be. For one thing, the Arkansas demonstration shows willingness on the part of insurers and networks to accept the poor, but only if the medically frail remain in Medicaid. This should provide some protection against a wholesale route with exceptions only for the nonelderly population that meets the Social Security Insurance disability test. Under this scenario, Medicaid presumably would remain accessible to those deemed inappropriate for a financing system that rests on principles of private financial risk, whose most important risk mitigation tools—risk corridors and reinsurance[63]–are set to expire after 2016.

For another, there is the cost entailed in such a transformation. Just as both the Government Accountability Office and the CBO have identified the relatively high costs associated with Medicaid as premium support, any effort to move Medicaid more decisively toward a premium assistance model inevitably will cost a good deal. This is not insurmountable either, of course. There simply need to be cost offsets. Securing funding for such a transition, if carried out with adequate safeguards, may have a significant effect on opening access to health care for the poor, at least in states in which insurers and their provider networks are willing partners in a premium assistance model. But when one is considering policy reforms in the land of the poor, offsets are hard to come by, and they have the potential to be even more damaging than the immediate policy at hand.

63. Patient Protection and Affordable Care Act §§ 1341-42, 42 U.S.C. §§ 18061-62 (2012).

IV. LOOKING FORWARD

It is difficult to say with certainty where all of this will end up. There are a lot of moving parts, and potentially, reforms that make it easier for states to use Medicaid to purchase qualified health plans sold in the Exchange may carry a larger price tag, for Medicaid at least. (This price tag could be offset by savings in federal premium subsidies if the movement of the healthiest beneficiaries into Exchange plans results in lower overall per capita costs for Exchange health plans). But there are also two fundamental truths. The first is that the nation has decisively moved away from the social contract principles that undergird Medicaid. And as the entire nation seemingly drifts inexorably in the direction of high deductible health plans that create huge holes in coverage, why should the poor not experience the same thing? I used to be asked by reporters how Medicaid reforms might help the populations that stood to benefit from them. Now I am asked why the poor should have good coverage when most Americans do not.

The second fundamental truth is Medicaid's remarkable endurance. Over its fifty-year existence, Medicaid has survived multiple near-death experiences and endless rounds of reinvention. Its eligibility rules have been reconfigured, as have its coverage parameters and delivery mechanisms. The program has struggled with periodic crises that have their roots in ideology and a particular viewpoint regarding what the government should invest in. But Medicaid has survived because it must. In a very real sense, the entire market-oriented system of health care financing—as seen clearly in the Arkansas model—depends on Medicaid's ability to fund health care for those whom markets literally do not want to touch.

How well Medicaid rises to the new challenge of joining itself to a private health insurance market, and whether its essential principles – comprehensive coverage; protection of the poorest Americans against cost-sharing; and availability at the time of need -- can survive remains to be seen. In an ideal world the ACA might have met these issues head-on and would have attempted to frame the point of juxtaposition in ways that gave these principles a somewhat better chance at survival. But the ACA was not born in an ideal world, and so taking Medicaid through its next iteration simply gets added to the to-do list.